STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF DELAWARE

ATTACHMENT 4.19-B

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES

OTHER TYPES OF CARE

Physician, podiatry, and independent radiology services shall be reimbursed based on CPT codes and definitions. Reimbursement rates shall be based on the Medicare Relative Value (RVU), adjusted by Geographic Practice Cost Indices (GPCI) representing the medical economic conditions specific to Delaware. Each CPT code has a unique RVU consisting of a Work Unit (WRVU), an Overhead Unit (ORVU), and a Malpractice Unit (MRVU). Delaware Medicaid may adjust the weight of each RVU up to, but not to exceed, 100% of the Medicare value.

Laboratories are reimbursed their usual and customary charge or a maximum fee for their service, whichever is lower. The maximum fee for each procedure will be reviewed annually. If such review indicates that fees should be modified, an inflation factor will be considered to apply to the fees which are currently in place; in addition, other aspects of the fee structure will be examined in light of usual and customary charges and other pertinent considerations to develop appropriate rates for the year.

TN No. SP-351	Approval Date JUN 2 2 1995
Supersedes TN No. SP-350	Effective Date 1/1/95

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

STATE OF DELAWARE

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OUTPATIENT HOSPITAL CARE

Reimbursement Principle

Effective with the start of the provider's fiscal year on or after July 1, 1994, the Delaware Medicaid program will reimburse A.I. duPont/acute care hospitals for outpatient services using the following payment methods:

- Prospective rate for visit services provided in the emergency room, outpatient clinic and outpatient delivery/labor room
- Submitted charges converted to costs for stand alone services identified by revenue code
- Fee schedule allowances for laboratory services

The base year for the outpatient payment methodology is FY92. Medicaid claims data and hospital cost reports from FY92 served as the sources of data for calculation of the outpatient payment amounts.

The established rates and methodology for hospital outpatient reimbursement shall be reviewed annually by the Delaware Medicaid program and adjusted, as necessary.

Rate Setting Method - Visit Services

Visit services will be paid using a prospective flat rate. There are four types of visit services:

- Emergency
- Non-emergency
- Clinic
- Delivery/labor room

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OUTPATIENT HOSPITAL CARE (Continued)

Rate Setting Method - Visit Services (Continued)

Each type of visit service is defined by a set of outpatient revenue codes. In addition, emergency visit services must be associated with an ICD-9 diagnosis code defined as a "true emergency" by the Delaware Medicaid program.

The flat rate for each visit service is based on a blend of the following:

- 75 percent of the hospital-specific mean billed allowed cost for FY95 for the revenue codes associated with the visit category

- 25 percent of the statewide mean billed allowed cost for FY95 for the revenue codes associated with the visit category

The hospital-specific mean billed cost was calculated using allowed charges from the Medicaid base year claims data associated with the revenue codes for each visit category. Allowed charges were derived from the claims data on a per visit basis for each revenue type using FY92 claims data. The allowed charges per visit included allowed charges for a standard set of revenue codes that identified drugs and supplies associated with the visit service.

The allowed charges per visit were then converted to cost using a hospital-specific cost to charge ratio for ancillary services from the hospitals' FY92 cost reports. A hospital-specific mean billed allowed cost was calculated for each type of visit by taking the mean of all the per visit allowed costs for the hospital converted from the claims data. The Statewide billed cost was calculated by taking the mean of all the per visit allowed costs across all in-state hospitals, except A.I. duPont.

Both the hospital-specific mean and statewide mean costs were inflated to the midpoint of the base year to the midpoint to the implementation year (FY95) using the DRI Hospital Marketbasket.

METHODS AND STANDARDS FOR ESTABLISHING PAYMENT RATES - OUTPATIENT HOSPITAL CARE (Continued)

Rate Setting Method - Stand-Alone Services

Stand-alone services encompass all other services provided in the outpatient setting that cannot be grouped into a visit category. A stand-alone service will be identified one of two ways:

- By revenue code
- By CPT code

Stand-alone services identified by revenue code will be paid using a hospital-specific cost-to-charge ratio for the revenue department. Each revenue code is assigned to a revenue department, based on the revenue departments listed in the hospital cost report. The cost to charge ratio for the revenue department was identified from the hospitals' FY92 cost reports and will be applied to the charges reported on the claim to obtain the payment amount for the revenue code.

Stand-alone services identified by HCPCS code will be paid using a fee schedule. Effective July 1, 1994, the only services to be identified using HCPCS codes are laboratory services included in the Medicare clinical laboratory fee schedule. These services will be reimbursed using the same methodology and fee schedule that is currently being used.

Effective for services provided on or after November 1, 1994, radiology services, identified by HCPCS code, will be reimbursed using a fee schedule.

Medical/Dental free-Standing Clinics are paid either a negotiated flat rate or as physicians are paid (see above).

EPSDT Services are reimbursed as follows:

see page 19

Family Planning Services are reimbursed a flat fee per service.

Transportation Services are reimbursed as follows:

1. Ambulance companies are paid a flat rate for any trip up to the first 10 miles and an additional amount for each additional mile.
2. DAST is reimbursed a negotiated rate.
3. Non-emergency medical transportation providers are reimbursed a regional base rate for each client plus a universal rate per mile. Delaware Medicaid will pay a differential rate added to the base rate for service provided between 6 PM and 6 AM on weekdays and 24 hours on weekends and State recognized holidays. Delaware Medicaid will pay a differential rate added to the base rate for transportation service provided in a vehicle equipped with a wheelchair lift required and occupied by a non-ambulatory client.
4. Non-emergency medical transportation by taxi is reimbursed at the metered rate. Taxi providers may be reimbursed for rideshare participants in addition to their usual and customary fee.

Optometrists and Opticians are reimbursed a set fee for examinations and another set fee for stock lenses. The reimbursement for non-stock lenses is made by prior approval by the Medicaid agency's Optometric Consultant.

Out-of-State Services, for which Delaware has established a universal rate or cap will be reimbursed at the provider's usual and customary charge or Delaware's rate/cap, whichever is lower.

Where there is no universal rate/cap (i.e., providers are paid a provider-specific rate), Delaware Medicaid will establish a rate or cap that is consistent with the reimbursement methodology defined in other sections of ATTACHMENT 4.19-B for that specific service, and pay the provider the lower of that rate/cap or their usual and customary charge.

Extended Services to Pregnant Women will be reimbursed at a negotiated hourly rate for individual services.

State: DELAWARE

Reimbursement Methodologies for Rehabilitative Services:

1) ***Community Support Service Programs***

General Provisions:
Payment for community support services is based on a fee for service, the rates for which are calculated on a prospective basis for each fiscal year. Rates exclude costs related to room and board. Rates are based on the provider's budget, projected census of active clients and productivity standards of billable staff time. Rates are based on each provider's projected operating expenses, and thus may vary from provider to provider. For each provider, a single rate will be paid for all service units, with the exception of Psychosocial Rehabilitation Center and Residential Rehabilitation Service units, the rates for which shall be separately determined.. These expenses are costs which are allowable and reasonable as defined within the Division of Alcoholism, Drug Abuse and Mental Health (DADAMH) Provider Reimbursement Manual. Prospective costs are the costs reported in each provider's annual budget submitted to DADAMH in accordance with the Division's prescribed methodology. Each provider's prospective budget and rate per unit of community support service is subject to approval by DADAMH. A rate setting committee (including representatives of the Department of Health and Social Services' Divisions of Social Services and Management Services) recommends the rates to be established for each provider by DADAMH. Providers are required to submit quarterly cost/expenditure reports against the prospective rate-setting budget.

New Programs:
New providers will submit projected costs of services. The rate setting committee will compare the provider's proposed budget against a statewide model budget to determine the reasonableness of various cost components. The prospective rate for providers of new community support service programs (other than Psychosocial Rehabilitation Centers and Residential Rehabilitation) will be initially set based on anticipated 40 percent utilization of budgeted billable units in the first year, 70 percent in the second year, 90 percent in the third year and 100 percent in the fourth and successive years. Psychosocial Rehabilitation Center services will be initially set based on anticipated 90 percent utilization of budgeted billable units in the first year, and 100 percent in the second and successive years. Residential Rehabilitation services will be established based on an anticipated ongoing occupancy rate of 90 percent. Rates for new providers will be set and reviewed semi-annually during the implementation years for each. Actual provider utilization of budgeted billable units will be monitored. A significant upward variation from that upon which the rate was initially set will prompt a prospective mid-year rate adjustment commensurately based upon utilization during the previous period.

13. Diagnostic, Screening, Preventive and Rehabilitative Services Other Than Those Described Elsewhere In This Plan. - continued

Audits: The Division of Alcoholism, Drug Abuse and Mental Health will conduct desk and field audits of providers to determine: 1) whether charges which have been billed are in accordance with federal, state and agency requirements; 2) whether services are being over or under utilized; 3) whether the provider is operating in accordance with the organizational, administrative and program standards of the Medicaid Provider Manual. These audits will include a review of each provider's actual costs.

I. GENERAL PROVISIONS

A. Purpose

This plan establishes a reimbursement system for Home Health services, including skilled nursing, therapies, and home health aide services. This system complies with federal requirements, including the requirement that Medicaid payments in the aggregate do not exceed what would have been paid by Medicare based on allowable cost principles.

B. Reimbursement Principles

1. Providers of Home Health services shall be reimbursed prospectively determined rates based on costs reported by each agency.

2. Skilled Nursing and Therapy services shall be reimbursed per visit. Home Health Aide services shall be reimbursed per hour.

3. Providers will be reimbursed prospectively the lower of their Usual and Customary charge or the rate.

II. RATE DETERMINATION

A. Cost Determination

1. Prospective rates for skilled nursing, therapies, and home health aide services will be computed from annual provider certified cost report data. Reimbursable costs are those allowable costs based on Medicare principles in accordance with HIM15, and subject to caps and ceilings determined by Delaware Medicaid.

2. Prospective rates will not exceed the Medicare rate limitation for the same services. Costs applicable to Home Health services shall not exceed the lowest cost of comparable services purchased elsewhere. The cost report used in the rate calculation will represent the most recent State audited provider fiscal year.

B. Rate Calculation

Skilled nursing, therapies, and home health aide services shall be reimbursed according to the cost of care determined prospectively up to a calculated ceiling. The total costs reported by each agency for each discipline will be divided by the number of visits to determine the average cost per visit. The inflated average cost per visit of each agency will be arrayed by discipline, and the ceiling set at the 75th percentile of this array.

C. Supply Costs

Supply costs will be reimbursed as part of the skilled nursing and home health aide prospective rates. The total cost of supplies as reported by each agency is divided by the sum of the skilled nursing visits and aide visits to determine the average supply cost per visit. The average supply costs per visit for each agency is arrayed, and a ceiling set at the 75th percentile of this array. The average supply cost of each agency, up to the ceiling, is added to the prospective rate for skilled nursing services. The average supply cost of each agency is multiplied by that agency's home health aide hours per visit ratio to determine the average supply cost per hour, and added to the prospective rate for home health aides.

D. Administrative and General Costs

Delaware Medicaid will not consider in the rate calculation administrative and general costs which exceed 40% of the total reported costs in each discipline. Total costs for each discipline will be capped before the costs are arrayed to determine the 75th percentile ceiling. The rate year from July 1, 1993 to June 30, 1994 will be considered a "hold harmless" period for the Administrative and General cost cap only.